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CHANGES IN THE SKIN AND ITS APPENDAGES FOLLOWING
LESIONS OF NERVOUS STRUCTURES.

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Read before the Boston Society for Medical Observation.

CHANGES of nutrition may occur in the skin, the subcutaneous cellular tissue, the muscles, the bones or the viscera. I have time now only to refer to the skin and the subcutaneous tissue.

Of the changes in the skin, the simplest is a more or less diffused erythema. Couyba reports two cases; in one, the erythema occurred five days, in the other six days, after the injury. He thus describes the eruption in one patient: "There is to be noticed, on the left knee, a red patch, as large as a two-franc piece. Its surface is quite regularly united, and it is not a simple redness, but rather there is a real elevation of the surface, with marked hyperæmia. By passing the fingers from the erythematous patch to the healthy skin, a slight prominence is felt at its edge." Later, a patch of pigment appeared on the thigh and other patches of erythema. The erythematous patch was hyperæsthetic.

I have seen one case where the erythema was very marked, the skin affected being that of the chest and shoulders, and part of the neck and arms. The skin was mottled, and resembled that of a case of scarlatina. There was no hyperæsthesia. I also reported a similar case to this Society, where the eruption followed an injury to the back, with loss of power in the legs, and hyperæsthesia of the parts covered by the eruption.

Couyba compares these erythematous patches to the "glossy skin," described by Paget and Mitchell. It is not the same. The erythema appeared soon after the injury, was elevated in patches, and, at least in many cases, lacked the glossy character.

Another change in the skin following nervous lesions was observed by Paget and Mitchell, and named "glossy skin." It is thus described by Mitchell: "The skin affected in these cases was deep-red or mottled, or red and pale in patches. The epithelium appeared to have been partially lost, so that the cutis was exposed in places. The subcuticular tissues were nearly all shrunken, and, where the palm alone was attacked, the part so diseased seemed to be a little depressed and firmer, and less elastic than common. In the fingers, there were often cracks in the altered skin, and the integuments presented the appearance of being tightly drawn over the subjacent tissues. The surface of all the affected part was glossy and shining, as though it had been skilfully varnished." "In most of them, the part was de-

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void of wrinkles, and perfectly free from hair." This state of the skin was always accompanied with burning pain; "in no case did it become visible short of two weeks, but usually it preceded the healing of the wound, and not rarely was to be traced to an outbreak of inflammation involving the wound." The duration varies from a few weeks to several years.

I have not seen any of the more acute cases, but the more chronic cases are not uncommon. Perhaps it is not to be expected that civil practice should give opportunity to see the severer forms which follow gun-shot and surgical lesions.

Pigmentation may occur in consequence of nerve lesion. Seeligmüller* reports the case of a child with lesion of the brachial plexus, where the sympathetic was affected. The eye on the affected side was a clear blue, on the other, a greenish grey. There was, also, atrophy of the face on the affected side.

M. Mayer showed to the Berlin Medical Society† a woman, 27 years old, with atrophy of the left side of the face. The color of the skin on the left side of the face was also changed: a yellow spot in the middle of the forehead, a white spot over the zygomatic process, and a white spot, resembling a cicatrix, on the upper lip. Also, there was a small lock of white hair, and a large number of white eyelashes. She had had epilepsy for six years, and for three years neuralgia of the left trigeminus. At about the same time with the neuralgia, the pigmentation began.

A scaly eruption is often seen in certain nervous affections. In the case I shall report, it accompanied neuralgia. It was preceded by oedema, and consequent swelling of the parts with hyperæsthesia. Fischer has seen this eruption follow the tract of the nerve. Instead of a dry, scaly eruption, this may be moist and vesicular, an eczema, or the vesicles may be larger and the eruption be herpetic, or bullæ may form. All recent authors who have written upon this subject refer to these vesicular and bullous eruptions. Charcot‡ reports a case, in which probable lesion of a branch of the radial nerve was followed by an eruption of bullæ on the dorsum of the hand, of the index, middle and ring finger. The bullæ appeared in the neighborhood of the joints, burst, and quickly healed up.

In the *Mémoires de la Société de Biologie* for 1865, Charcot, with Cotard, reports a case of cancer of the vertebræ, where the fourth cervical vertebra gave way on the right. There was an eruption of herpetic vesicles over the whole right side of the neck. The ganglia on the roots of the cervical nerves, and the trunk after the union of the roots were swollen and congested. Under the microscope, no change could be seen in the nerve fibres or cells, but only the increased fulness of the bloodvessels.

Ulcerations are seen to follow lesions of nerves, especially near the nails,§ perhaps due to the irritation of the curved nails. Bed-sores may be mentioned in this connection. The ulcerations in the trachea or bronchi and œsophagus, in cases of aneurism of the aorta, may be due to pressure of the aneurism upon the nerves; the recurrent laryngeal and pneumogastric are especially exposed to pressure. In one

* Berliner Klin. Wochenschrift, 1870, page 313.

† Wiener Med. Presse, 13 Feb., 1870, page 149.

‡ Journal de Physiologie, 1859, page 108.

§ Couyba, page 16.

case, I saw an ulceration or local inflammation in the lower part of the peritoneal cavity over the rectum, and could find no cause for it, all the rest of the abdominal cavity being healthy. The patient was paraplegic.

The nails are variously altered. They are more sharply curved transversely, and the ends may curve over the ends of the fingers; they may be thrown up in ridges, become brittle and break easily, may be changed in color, becoming yellowish, and may be retarded in growth, or, for a short time, cease to grow. In two of the cases I report, the nails were very much changed.

The hair may fall off and cease to grow, or be very much dwarfed in its growth, as is seen in the cases of "glossy skin." Or it may be much more luxuriant. A remarkable case of the latter appearance is reported by Dr. Jelly, in the *British Medical Journal* for 1873. A boy, 18 years old, had complete paraplegia from a fall. His hair had grown to an extraordinary length over the whole body, back and front, below the last dorsal vertebra; but was longest from the nates to the middle of the thigh, being so long there that it could be easily curled.

The hair may change color. Dr. Victor Urbantschitsch reports a case* where the hair turned white over the region supplied by the auriculo-temporal branch of the fifth nerve, after an abscess in the ear. An abscess on the other side followed with alopecia.

Again, the hair may only become coarser, and hard and harsh. Anstie mentions these changes of the hair following neuralgia.

The subcutaneous cellular tissue may become oedematous, may be thickened and hardened by interstitial deposits, or abscesses may form and cause much trouble, or there may be atrophy. Oedema is frequently seen in paralyzed limbs, whether the paralysis is central or peripheral. Romberg refers to a case of sciatica, reported by Cotugno, where there was oedema of both legs; the patient died of typhus fever.† Several authors report swellings which resembled abscesses, but which disappeared and returned much too rapidly to be inflammatory. In one case, an incision was made without finding pus. I have seen a patient who reported that he had such swellings, which would appear and attain a large size in a few hours, and would disappear as quickly. I never saw one of them.

In one of the cases to be reported, felons were found on each finger, except the little finger. Fischer‡ mentions such. "Without general disturbance, and without severe pain, the last phalanges of the fingers are swollen like a knob. The swelling remains firm for a while, then softens. Deep abscesses are opened, which penetrate to the bone, and this may be carious or necrosed. These abscesses heal slowly, or not at all, and always cause deformity. On the feet, they sometimes resemble *mal perforant*." Duplay and Morat§ give an account of the *mal perforant du pied* as a neurosis.

Atrophy of the subcutaneous tissue, in cases of nerve lesion, will account for some cases of atrophy, as, perhaps, in two cases of facial atrophy already referred to, and in other cases, especially some reported by Lande. The diminution in the size of the fingers in one

* Wiener Med. Presse, 1874, page 765.

† Sydenham Society Translation, Vol. I. page 66.

‡ Centralblatt, 1871.

§ Archives Générales, 1873.

case to be reported was probably due chiefly to the atrophy of the subcutaneous tissue.

Nicati refers to atrophy of the capillary network as preceding the atrophy of the connective tissue.

Mitchell reports one case of hypertrophy of connective tissue after wound of nerve.

The secretions of the skin may be altered. The perspiration may almost cease, so that the skin is dry and harsh, or it may be in excess of that on the healthy side, or it may be altered in quality. I have seen one case in which the affected side was bathed in profuse perspiration, large drops standing upon the skin, while the healthy side was comparatively dry. In one of the cases to be reported, the patient mentioned the excess of this secretion on the side which showed the most marked nutritive changes in the skin. Mitchell, Morehouse and Keen mention one case where the sweat was intensely acid, so that an odor of vinegar could be smelt at all times in the neighborhood of the man. In one case, they state the odor of the sweat was disgustingly heavy, and resembled the smells from a bad drain.

The sebaceous secretions are generally not mentioned. Where the skin is very dry, and the hair feels harsh, it may be supposed to be diminished. Lande says it is diminished in cases of facial atrophy.

This is a very brief sketch of the changes in the skin and its appendages following nerve lesion. These changes may result from irritation or from paralysis. From paralysis may follow oedema, with infiltration and induration, perhaps pigmentation, atrophy, and, possibly, simple erythema, though the erythema in the cases which I noticed could not be certainly referred to paralysis. Most of the changes, however, must be considered as arising from irritative lesions. This is the case with "glossy skin," with the vesicular eruptions, and, probably, with the lesions of nails and hairs. Bed sores and other ulcerations must also be referred to irritation. A dry, harsh skin, with absence of sweat and of the sebaceous secretions, is referred, by Mitchell, to paralysis; where the secretions are excessive, to irritation.

We may be able to judge in part from the nature of the nutritive change as to the seat of the nervous lesion. I am not aware that "glossy skin" has been found, except in connection with peripheral lesions. Judging from the few autopsies, it may be safe to say that vesicular eruptions are dependent upon lesion of the spinal ganglia or nerve roots. Charcot, indeed, refers to cases where such eruptions were found in cases of central lesion, but he says those observations are reported in a very summary manner, and he refrains from drawing any deductions from them. On the contrary, he reports such a case, zona on the paralyzed leg in a case of hemiplegia from cerebral softening, occurring at the same time with the hemiplegia. At the autopsy, besides the softening, a branch of a spinal artery, plugged by a clot, was found attached to one of the posterior roots of the chorda equina.

The cases of erythema reported by Couyba, and those which I have seen, followed spinal lesions. Ulcerations, especially bed-sores, are found in central lesions, spinal or cerebral. In spinal lesion, the bed-sore is usually over the sacrum, near the median line. In cerebral lesion, it is more likely to be on the side over the gluteal region.

Attempts have been made to refer these changes, some to the influence of the vaso-motor nerves, some to that of special trophic nerves.

It does not seem at all likely that they all can be dependent upon vasomotor changes alone. I will not, however, attempt to make any definite division.

The following cases will illustrate some of the cases above described. The second case also presented changes in the muscular and osseous systems.

CASE I.—Fall; Injury to Wrist; Deformity of Hand; Nutritive Changes in Skin and Nails.

Mr. B. H., seen in June, fell on the ice in the January previous, striking the right hand. There was not much pain from the fall. The hand, so he said, was of the same shape immediately after the fall as now. It was put up in splints, and taken out about four weeks after the accident, and has been stiff since. Now, the metacarpal bones seem to be dislocated to the radial side, the radius and ulnar seem to be unaffected, the carpus is in some way displaced, and the back of the hand is strongly arched. Exactly where and what the injury was, I will not undertake to decide.

The thumb is curved into the palm, the fingers and wrist are much restricted in their motions. The fingers are glossy, the nails narrower, sensation is unimpaired, the hand is somewhat œdematous.

Oct. 15th.—The right hand is less œdematous, the knuckles of the fingers apparently are more swollen; first phalanx of the middle, ring and index, each measure one-eighth of an inch less in circumference than the corresponding parts on the right. The little fingers are equal in size, as are, also, the thumbs. The joints are equal in size on the two hands, except the last phalangeal joints. The skin is whitish, shiny and dry, that on the fingers being more so than that on the hand. The nails are curved laterally, are very narrow, and of different color from the other hand. There is pain nearly all the time in the hand, but not severe. The motions of the wrist are rather freer, of the fingers about the same as in the early summer. Supination causes pain, pronation is less painful. All the fingers, except the thumb and perhaps the index-finger, are numb, both on palmar and dorsal aspect.

CASE II.—Progressive Muscular Atrophy on the Left; Changes of Nutrition in Skin, Cellular Tissue and Bone on the Right.

Jane McG., aged 27, seen May 4, 1872. Family history shows no special nervous taint. The patient was healthy till she was 17 years old, except relapsing fever when about 11 years old. For the last six years, she has had "inflammatory rheumatism," not a month passing when it did not "pain her," in the right arm, back of the neck, left side, down the back; never in the legs. In the right side of the head, behind the ear, shooting pain and cold chills for about five years. When the "rheumatic" attack in the right arm first appeared, she had been working at her trade as seamstress rather more steadily than usual, and had been at work pretty steadily for five years previously. The pain was at first burning in character, with heat in the arm, without swelling; the pain was very severe in the wrist. She continued to sew, but could not do her work well, and had to give up sometimes on account of pain and weakness. Sometimes, when holding a needle, her fingers became cramped. At the beginning, the thumb and forefinger pained her; once in a while, there were cramps before the pain. In about three weeks, the pain extended from the hand to the elbow, and in about three months, to the shoulders and neck. Pain has con-

tinued since, but the cramps in the fingers have been present only once in a while.

About seven years ago, she began to have trouble in the left arm. Gradually, a weakness came in the fingers, and they drew up. She could not hold her work; there was pain and heat in the fingers, beginning first in the little finger, then spreading to the other fingers and thumb, then to elbow and shoulders in about nine months. The pain was not severe, but tiresome. About six years ago, she could not raise her hand to her head, and it has been growing worse since. No cramps in left arm. Has had headaches at times, since arms have troubled her; also, has been dizzy, sometimes eyesight dim.

Both pupils acted well; the right was slightly enlarged. The external rectus on the right did not act quite so quickly as the internal; there was no strabismus. The right eye moved less steadily, in following a moving object, than the left. There was no facial paralysis, or numbness of the face. When there is pain in the neck, the head and face flush, and then she cannot see well. Sometimes, however, the face is pale when the pain is present in the neck. The flushing is most marked on the right side of the face, and she sweats more on that side.

The left fingers and hand were much wasted, and the fingers were contracted; the skin over the two distal phalanges was abining and whitish, less so over the first. The contraction of the fingers was gradual during five or six years. Three years ago, there was a swelling in the palm, which was opened, and pus evacuated. The motions of the left arm were much interfered with. She can pronate and supinate the hand; can shut the fingers, if they move together; can only half extend them; cannot spread fingers apart. Motions of thumb are restricted. Motions of wrist are nearly normal, except as to flexion. She can flex the elbow only slightly when the upper arm is abducted. Cannot raise her arm to the horizontal; can abduct and adduct arm, and move it forward and backward.

The supra- and infra-spinatus were much wasted, as were, also, the posterior portion of the deltoid, the pectoralis, biceps, thenar and hypothenar eminences. These, and the flexors of the fingers and interossei, acted poorly to the induced current, better to the galvanic. Snapping the muscles, deltoid, triceps and others, caused fibrillary contractions on the left. The motions of the right hand and arm were good, and about normal in extent; snapping some of the muscles on the right, caused slight fibrillary contractions.

About three years ago, she began to have felons on the right hand, first the middle finger, then the ring, then the index, then the thumb. The little finger was not thus affected, but it was contracted. The fingers were much deformed, the joints being enlarged, the nails misshapen, and the last phalanx of the middle finger was gone. The skin was shining. The sensation was much diminished in the right arm, and on the right side of the neck behind the ear. With the ophthalmoscope, the papillæ were very red, the vessels on entering became fainter, as if covered by a thin film.

It will be noticed that the muscles and motor nerves were chiefly affected on the left; the sensation and skin, with its cellular tissue, and hence the sensitive nerves, mostly on the right.

CASE III.—*Neuralgia, accompanied with Scaly Eruption.*

Miss A. B., aged 42, was first seen about three years ago, and again two years ago, and frequently since. She has been troubled much with neuralgia, dating from unusual excitement and over-exertion, when young. The neuralgic pain has affected different parts of the body, first in the epigastric region, then in the arms, and has been frequently in the head, in the form of hemicrania. Sometimes, the pain extended from the head down the back, and also into the chest. The headaches come on with flashes before the eyes. A small, stationary, black spot was perceived in the right eye, sometimes in the left. This is not seen, except during an attack of headache, or when over-tired. The pain begins just behind the left ear, then goes over the left eye, down over the cheek and nose on the left side, and then becomes general. Then there is a twitching in the left arm and leg, and then on the right side; sometimes this twitching is very strong.

When the neuralgia attacks the arm, there is developed, in a short time, a condition such as I saw in the right arm. There were tender spots over the median and the musculo-spiral nerve above the elbow, also over the median at the bend of the elbow. When the neuralgia first appears, the hand on the affected side swells and is very sensitive, so that it is disagreeable to touch any object. Subsequently, the epidermis scales off, and when I saw her the palm of the right hand, mostly on the ulnar side, was covered with a thick, scaly eruption. This eruption followed the neuralgia, increased with the increase of pain, and diminished when the pain decreased. When the pain ceased, the eruption disappeared.

Progress in Medicine.

REPORT ON SURGERY.

By J. COLLINS WARREN, M.D.

ESMARCH'S "BLOODLESS SURGERY."

PROF. ESMARCH, whose paper on this subject has excited so much interest, finding, on a recent visit to England, that many surgeons were but imperfectly acquainted with his method, that others applied it, but not in the right manner, while others attached no importance to the avoidance of hæmorrhage during an operation, took occasion to read a paper on the value of this method before the Clinical Society of London. The paper was subsequently published in the *British Medical Journal* for Oct. 17, 1874. He finds the influence of this method on the mortality after the greater operations to be decided, especially after amputation of the limbs. He says:—"I lately compared the results obtained in my practice after operations performed bloodlessly, with the recently published results of operations performed by other surgeons, and I found that my results were much better than the best of these, including even those in which the antiseptic method had been strictly followed." Thinking, however, that a more just comparison would be that between cases occurring in his own practice and performed in the same hospital, previous to the application of the bloodless method and afterwards, he gives the statistics of the operations performed by him during the last six years. "Of 88

amputations of the thigh, performed in the first five years, there died 37, or 42 per cent. Of 67 amputations of the leg there died 19, or 28.3 per cent. After the adoption of the bloodless method, there died of 13 amputations of the thigh, only 1; so that the proportion of fatal cases in amputations of the thigh and leg together is brought down from 36 to 8 per cent." He is of the opinion that these statistics, admitting the error which may result from the difference of the numbers compared, afford such striking evidence of the value of bloodless surgery that no one should neglect this method in cases to which it is at all applicable. He thinks it should not be limited to operations on the extremities, but should be extended to other regions with such special modifications as each case may require. He has used it in amputations and excisions of the shoulder joint, in operations on the male genital organs of such an extensive character that they could not have been attempted under former circumstances. In the three hundred cases in which he has used this method, he has met with no evil consequences which could be attributed to it. The longest operation which he performed by this method lasted two hours and a quarter. It was a case of necrosis of both tibiae, with suppuration of the knee-joint on one side, in which he first removed many pieces of dead bone from one tibia, and then performed resection of the knee-joint, his assistant being at the same time engaged in operating for necrosis on the other limb.

HERNIA.

Charles Steel, F.R.C.S., in a paper read before the Bristol and Bath Branch of the British Medical Association, says of Wood's operation for the radical cure of hernia, that, although it is highly successful in its author's hands, it has been frequently attended with fatal results in the practice of other surgeons. He adds, "now that trusses are made so scientifically to fit and support, it is unjustifiable to perform an operation which is attended with much risk of life; at the same time, when good prospect of permanent success, with but little risk of life, is offered by operation, it is right to endeavor to save patients from the life-long trouble of wearing a truss, especially as the existence of a hernia disqualifies men from certain services and duties." He recommends a method of operating which, although thought out by himself, he finds substantially described in Gross's Surgery. It consists in making an incision between, and parallel to, the pillars of the external ring, and dissecting down until the pillars are fairly exposed. Their edges are scraped with a scalpel to roughen them, and they are then brought together by catgut sutures, the wound being treated antiseptically. The writer attaches great importance to the subsequent use of a proper truss to give time for effused lymph to become firmly organized, otherwise there is liability of the hernia to be reproduced at any time within a year of the operation.

Strangulated Hernia.—Dr. Herman Lossen (*Centr. für Chir.* No. 4, 1874; *London Med. Record*, July 8, 1874) gives an account of experiments made by him for the purpose of determining the mechanism of hernial strangulation. He states: "For the reduction of those cases of hernia in which, from inflammatory swelling, a protruding intestine has so much increased in volume that it cannot be pressed back through the same aperture by which it protruded, there exist two

rival theories: Roser's valve theory, and Scarpa and Busch's theory of pinching of the intestinal canal. To decide whether either of these be correct, and if so, which is the more so, I repeated Busch's experiments with fresh pig's gut; but, instead of water, I used melted wax, which, on cooling, became a solid mass. The hernial apertures were represented by holes bored through the lid of a cigar box, through which a finger might pass. The casts of the loops, after removal of the artificial hernial rings, were now embedded in wax of another color, and vertical sections made through them. In the same fashion, a number of loops inflated with air were artificially strangulated and then dried."

The following results are demonstrated by these preparations and experiments:

1. At the moment when the wax, or air, or, in the living gut, the faecal matter, enters the afferent end, the efferent portion of the gut, at the level of the hernial aperture, is pressed together, and by the constantly increasing pressure is finally completely closed.
2. This being accomplished, no pressure, however great, coming from above, will re-open the distal end of the gut.
3. The pinching (*Abknickung*) of the intestine, which is principally referred to the opposed folds of mesentery, is not the cause, but the consequence, of this closure.
4. The afferent end is never closed, which appears to contradict the hydrostatic law that in a closed space lateral pressure acts equally in all directions, and perpendicularly to the surface. According to this law, the pressure in a strangulated loop must exist up to the level of the hernial ring; and above it, in the afferent piece of intestine, a diminution or increase of pressure must manifest itself equally in all directions.

This may be demonstrated with extreme facility by means of a manometer attached to the afferent end of the artificially incarcerated loop of intestine. It may be shown in this manner, beyond all doubt, that in the living intestine the whole column of excrement presses upon the contents of the bowel in the strangulated loop. Therefore the pressure on the sides of the loop will depend upon the height and length of this column, and upon the resistance the intestine offers to the pushing back of the faecal contents. The height of this column may become considerable by reason of the long continuance of the strangulation. During this time the pressure constantly augments, but it possibly may be reduced by severe faecal vomiting. The impediments arising from friction are the most important. These, from the very outset, are in inverse proportion to the transverse section of the hernial aperture; they depend further upon the viscosity of the contents of the bowel, upon the number of 'pinchings' of the intestine occasioned by the gradual swelling of the convolutions of the bowel above, and also upon the contractile force of the pylorus and of the ileo-caecal valve. They increase with the increasing peristaltic motion and swelling of the intestinal coverings, in consequence of which the afferent end may ultimately assume the minimum transverse section.

The author's observations and experiments show how great the lateral pressure upon the loop may become. It is manifest that the maximum of lateral pressure immediately above the hernial aperture must be attained at the time when that pressure equals the sum of the

resistance due to impediments in the whole upper tract of the bowel. From this moment must commence a backward motion of the contents of the bowel, the fluid particles flowing back in the axis of the canal, whilst along the walls the peristaltic influence will urge the matter forward. In the strangulated loop these movements are reversed, and maintain the equipoise. Under these circumstances, the pressure does not further increase.

In the living subject, the resistance is much greater than in the dead, in consequence of the peristaltic action, the viscid nature of the bowel contents, and the smaller size of the hernial aperture.

The manometer shows that all species of direct pressure upon the tumor increases the tension, and aggravates rather than improves the condition of affairs. Neither Roser's nor Busch's theory explains this. It is the lateral pressure at the orifice of the sac which alone prevents reposition.

A rational taxis then will renounce attempting any alteration at the afferent end. The efferent end is the one to be opened. "This is to be effected," Dr. Lossen says, "as I am in a position by the manometric experiment to prove, by pressing the loop of intestine towards the side of the afferent end. The efferent end is by this means opened, and the loop partially empties itself, then a slight pressure upon the hernial swelling is sufficient to effect reduction."

Seeing that no practical diagnostic means are known whereby it can be accurately ascertained at what side, the right or left, the upper or lower, the efferent end may lie, the author recommends that side-ward movements of the hernial swelling be carried circularly round. If this end be not attainable, an external herniotomy may be made, and then similar manipulations again tried before incision of the ring.

From the preceding it is also clear that, in the internal treatment, laxatives must not be administered, and that large doses of opium are to be commended immediately after the occurrence of strangulation. The peristaltic action will be thereby lessened, and thus one provocative of lateral pressure eliminated.

On the Action of the Muscles in Strangulated Hernia.—Motte, having made numerous observations and experiments on living men and animals, comes to the following conclusions (*Bulletin de l'Académie Royale de Méd. de Belgique*, 1874, No. 6; *Centr. für Chir.*, No. 32):

A hernia can be produced without any participation whatever of the muscles; for example, of the diaphragm.

The muscles of the abdominal walls can present more or less of an obstacle to the reduction of a hernia, and increase the strangulation. This is not, however, usually the case, and there is never any condition of permanent spasm. Of the different positions which are recommended to relax the muscles, and to allow the hernial aperture to be opened to its fullest extent, there is not a single one which effects this with certainty in all cases.

In performing taxis, the operator should not adhere to any one method, but if the reduction is difficult, should try various positions.

TETANUS.

The treatment of tetanus by the injection of chloral hydrate into the veins has given rise to a good deal of discussion. Even those opposed to it allow that the remedy has the effect of relieving the symptoms. Rest and sleep are ensured, and ability on the part of the patient to

receive nourishment. The injection of chloral into the veins is said to be dangerous, inasmuch as it causes coagulation of the blood; it is, moreover, unnecessary, as the drug can be introduced into the stomach through a tube.

It is maintained that chloral does not cure the disease, as only chronic cases have been cited, and these always get well of themselves. Verneuil, however, contends that this division is a purely artificial one, as it is impossible to establish a differential diagnosis at the outset of the disease. The dose is large—six to ten grammes, in double the quantity of water—given until all symptoms yield. A reference to this subject is to be found in the *Centralblatt*, No. 45, 1874.

ANÆSTHESIA.

Dr. Jacob Helberg, of Christiania (*Berliner Klinische Wochenschrift*, No. 36, 1874), proposes a substitute for the present method of relieving difficult or impeded respiration during anæsthesia. The use of the gag to pry open the mouth, and of the forceps to drag forward the tongue, is frequently attended with some injury to the mouth, of a permanent character, or, at least, may be followed by a sense of discomfort, lasting for some days. His procedure consists, simply, in dragging forward the lower jaw-bone, and is described by him as follows: "Standing behind the recumbent patient, the two thumbs of the operator are placed upon the symphysis of the lower jaw, while the index fingers are hooked behind the ascending ramus of the jaw. The bone is then pulled forcibly forward (anatomically). The force should be applied as if the operator intended to lift the patient up by his jaw-bone. During anæsthesia, the head of the bone slips forward with a perceptible jerk, and the whole lower jaw overlaps the upper jaw. As soon as this is accomplished, which is easily done in children, a deep, full inspiration follows, immediately, and continues as long as the bone is held in position." The author supposes that the epiglottis is thus lifted off the rima glottidis.

A CRUEL JOKE.—A surgeon living in a colliery district near Thornley was recently made the subject of a very cruel joke, says the *Pall Mall Gazette*. Word was brought to him that a terrible accident had occurred at a colliery in the neighborhood, and he was urged to lose no time in going there with instruments, splints, lint and bandages. He hurried off accordingly, most elaborately prepared, and, the news having spread, he was followed with no less haste by numbers of the villagers. An accident had really happened near the pit's mouth. In the high gale which did so much mischief a few days ago, a travelling waxwork show which had been exhibited to the miners was blown over, and the surgeon found that the patients for whom he had run himself out of breath were life-like figures of Mary Ann Cotton, who had lost one of her arms; Tropmann, the French murderer, whose skull had been fractured; and several other inmates of the "chamber of horrors," who had broken legs or arms, or received injuries more or less serious. The surgeon's disappointment and disgust deserve heartfelt sympathy. On public as well as on private grounds, too, these unseemly jokes should be discouraged. It would be exceedingly convenient if, in colliery explosions and railway accidents, lay figures could be blown up or smashed in the place of the actual sufferers. As, however, science has not hitherto perfected any such system of vicarious sacrifice, very awkward consequences may ensue if practical jokers permit themselves to trifle too often with medical men, and thus lead them to stay away when they are really wanted.—*Medical Press and Circular*.

Reports of Medical Societies.

MIDDLESEX EAST DISTRICT MEDICAL SOCIETY. AZEL AMES, JR., M.D., SECRETARY.

The Society met in Reading, Nov. 18th, the President, Dr. S. W. ABBOTT, in the chair.

Complete Laceration of the Perineum and Sphincter Ani, complicated with Incontinence of Urine. Recovery. Dr. FRANCIS F. BROWN reported the case.

Mrs. L., aged about twenty-five, a woman of good health, was taken in her first labor, April 24, 1874, about 10 P.M., membranes rupturing at that time. Saw her for the first time at 9 P.M., the 25th. Found os uteri slightly dilated; external parts rigid and sensitive, as they were throughout the labor. She had suffered much pain during the whole twenty-four hours. Thus she lingered till noon of the 26th, when the os was two-thirds dilated and dilatable. At half past twelve, April 26th, thirty-nine hours after the commencement of labor, I applied Hodge's long forceps, telling the nurse and husband that there would be laceration and they must not blame me for any unfortunate result. I had twelve ounces of sulphuric ether with me. It took considerable of it to bring her under its influence, and I soon found that more would be needed. It was sent for; but, before its arrival, the woman was delivered of a living child, one hour and three-quarters after commencement of the inhalation. In consequence of the sparing use of the ether, the patient became unruly and hard to manage. Once the husband lifted her with a jerk, and laid her down suddenly, so as to bring from me an involuntary exclamation of fear of injury.* Considering the high position of the child and the rigidity of the external parts, the forceps were introduced with less difficulty than I expected.† The head presented; vertex to the right sacro-iliac synchondrosis, rotating so as to bring the occiput to the posterior fourchette, and the forehead under the pubes. The perineum was lacerated during the passage of the head. The placenta was soon delivered, and the rent carefully examined. It extended entirely through the sphincter ani, and one half an inch into the rectum. The wound was carefully closed with three deep quilled silk sutures, one of which passed through the sphincter muscle. Remembering the success of the elder Dr. Stevens, in a similar case, I hoped for a like good result. The urine had been passed by the patient before etherization; it was now drawn with the catheter, looking turbid, as I recollected afterward, but whether with blood, in the hurry of the moment was not noted. Pulse 120, immediately after delivery; 110, three hours afterwards. She passed a comfortable night under opium. The next morning, I introduced the catheter and instructed the nurse, who had been accustomed to use it, to do it in the evening. What was my horror the next (second) morning to learn that the urine had flowed involuntarily from my patient twice during the night. Here was a pretty fix. A vesico-vaginal fistula, as I thought, in addition to complete laceration of the perineum! For weeks or months this delicate,

* I cannot help thinking that the incontinence of urine resulted from injury produced at this moment.

† The blades being accurately applied to the sides of the head, reaching to the middle of each cheek, as was plain after delivery.

petted lady must live, befouled and excoriated by her own excrements, to be relieved only by a surgical operation which would necessitate her removal to a distant hospital! Such was the dismal future that rose before me at that moment.

For the next two weeks, gentlemen, there were at least two miserable people in Reading, this patient and her doctor. I need not describe her condition, lying on her back, constantly bathed and excoriated by decomposing urine, from which no skill or care could protect her; happy in this, however, that she was ignorant of the real extent of her injury.

The sutures were removed on Saturday, the seventh day after labor. As the wound had been constantly wet with urine, I expected to find no union, and, according to my notes and my recollection, there was none. The most unexpected and fortunate recovery which followed makes me doubtful of the correctness of my observation. I did not separate nor draw upon the lips of the wound, which were in apposition, wishing to avoid possibility of harm, so there may have been slight adhesion; but I set it down at the time, in my mind and notes, that there was none. On the eleventh day, the bowels, which had been kept, all this time, quiet by opium, were freely moved by citrate of magnesia; there was not the slightest control over the feces. The next day, twelfth after confinement, on account of uneasiness in the parts, I used the syringe to clean the lower end of the bowel, being careful to insert and direct the pipe well back towards the coccyx, away from the wound. The water flowed from the vagina and the perineal rent, the anterior part of it at any rate, as fast as pumped into the rectum.

May 9th.—Two days afterwards, the fourteenth day after the confinement, the bowels moved spontaneously. There was no control over their motions as yet. But now comes a pleasanter part of my story. A fortnight had now passed as described. The urine, with the exception of the first twenty-four or thirty hours, had been constantly dribbling away, as fast as it entered the bladder. Now, it was noticed that the flow was not constant, but sometimes, at first during sleep, ceased; at first, half an hour, then an hour, then two hours; and about May 14th, nineteenth day after labor, complete control over the bladder was regained.

At the same date, examination showed, to my astonishment, that the perineum was healing. Opium was continued till the 16th, twenty-first day after labor, when a dejection, after Seidlitz powder, proved that my patient had recovered control over her bowels also.

On May 20th, twenty-fourth day after labor, a more thorough examination being made, previous ones being incomplete for fear of injury, revealed a solid perineum about three-fourths of an inch broad and one-half of an inch thick, and a small recto-vaginal fistula. An enema into the rectum would partly flow from the vagina, but solid feces never passed this way after this date. Within a month, that is by June 20th, this opening *had entirely closed*. Since July she has enjoyed good health. Has slight uneasiness after urinating, and sometimes darting pains, which seem, as near as I can make out, to proceed from the seat of the wound. There is no bearing down or dragging sensation, or feeling of loss of support, "as if every thing is tumbling out."

Now, as to the incontinence of urine, I am inclined to the opinion

that it was due to a vesico-vaginal fistula, although no examination was made to settle the point. The extreme soreness of the parts, and the fear of disturbing the perineal rent, with my belief that nothing was to be gained for my patient by an immediate examination, led me to defer it from day to day till her recovery from this difficulty made it unnecessary. Might not this trouble have been due to paralysis of the sphincter of the bladder, rather than to a fistula? Her spontaneous recovery may make this seem probable. On the other hand, vesico-vaginal fistulae are occasionally known to heal spontaneously. Two members of our Society, Drs. S. W. Abbott, of Wakefield, and Wm. F. Stevens, of Stoneham, have each had such a case. Dr. Abbott will report to you his case himself. In Dr. Stevens's patient, there was an opening into the urethra or bladder, probably the latter, for there was entire incontinence of urine, following rapid delivery without instruments. The fistula was probably the result of a rent, and not a slough, for the incontinence followed soon after the birth of the child. Bearing on this point are cases of chronic perforating ulcer of the bladder cured by Sir James Y. Simpson by putting the viscus into a state of physiological rest by means of an artificial vesico-vaginal fistula, effected by introducing a grooved staff along the urethra, and slitting up the posterior fourth of the canal and about one inch of the posterior wall of the bladder. There was no difficulty in getting the fistula to close after the ulcer had healed; the difficulty was to get it to remain open long enough.*

Dr. Emmet, of New York, performs the same operation with similar results; all of which seems to show that however difficult it may be to heal a fistula in which there is a loss of substance from a slough, a clean cut readily closes. Paralysis of the bladder after labor, whatever we might expect from reasoning on it, usually results, not in incontinence of urine, but in retention.

Here there was no retention after the first thirty hours, but the opposite condition, and the bladder was constantly empty. Most accidents of this kind are supposed to be due to long pressure of the head on the bladder and urethra after the descent of the head has begun, causing a slough which separates in from four days to two or three weeks. In this case the head had not begun to descend when the forceps were applied; and I think the injury may have been caused by one of the blades making a small cut, not quite through some part of the bladder, during some of the movements of the patient when partially under the influence of ether, as before mentioned.†

In regard to injuries to the perineum, Professor T. G. Thomas, of New York, says:‡ "It may be affirmed, in a general way, that any laceration which does not entirely sever the sphincter ani may heal without surgical treatment, and that none which converts the two passages into one will do so. Even when the rupture has been complete, it has been asserted that spontaneous cure has taken place, but such reports need confirmation. Peu once affirmed that he had seen a woman thus injured, and who passed her feces involuntarily, entirely recover. De la Motte declares that thirty years after-

* See Braithwaite, July, 1871, page 224.

† No attempt was made to keep a catheter in the bladder, under the (perhaps mistaken) idea that the irritation of its presence would counteract the good it might do. In another such case I would try it.

‡ Diseases of Women, page 115.

wards he met and examined Peu's patient in Normandy, and found that no recovery had occurred." In my patient, every fibre of the sphincter was torn through, converting the two passages into one. This has completely healed as, I have described. Whether the cure was spontaneous, or whether there was some union at the time of the removal of the sutures which I overlooked, I leave you to judge. Spontaneous or not, union under such extremely unfavorable circumstances was entirely as unexpected as it was fortunate.

Treatment was mainly by opium, rest and non-interference of the parts—I should have liked to add, cleanliness, but that was out of the question.

1st. Opium was well borne; I have never seen it act more happily, constipating the bowels, giving the patient quiet and sleep, and benumbing a keen sense of misery. She was kept well under its influence for three weeks, and partially so a while longer. There was no trouble in leaving it off.

2d. Rest. For nearly three weeks she was lifted from one side of the bed to the other, not exerting herself in the least, not even moving her legs, nor separating her knees.

3d. The injured parts were interfered with as little as possible; no examination of the leak from the bladder was made for fear of disturbance of any healing which might possibly be taking place.

Allow me a few words more in justification of myself. Perhaps some of you may think that in relating this case I have been exposing my own blundering and lack of judgment and skill. If so, I hope it may be of possible benefit to some who may escape my mistakes by knowing them. In the first place, perhaps I was wrong in not having council. It would have saved me some anxiety afterwards to feel that other shoulders were helping to bear the load of responsibility, but at the time I did not think it was necessary, nor do I now even. The case did not seem more difficult than many which I had conducted to a successful determination, and had the ether not given out just in the nick of time, would not have been.

Secondly, were the forceps applied at the proper time? I had remained and watched the woman all the forenoon. She had been thirty-nine hours in labor, the external parts rigid, os dilating slowly; she had lost two nights' sleep, and I feared exhaustion, and determined therefore to apply the forceps as soon as I could, and did so. If I had a like case again, I should try chloral; Dr. Playfair in the *Lancet* for February, 1874, calls attention to its value in the first stage of labor, where the os uteri is rigid and dilating slowly, with much pain. Fifteen grains repeated two or three times at intervals of twenty minutes or half an hour, diminishes the pain, dilates the os, and hastens labor. My experience in a few cases is confirmatory of this testimony.

Thirdly, as to the laceration of the perineum, I expected it, and was so sure of it that I told the nurse and husband, before applying the forceps, that it was inevitable—a remark I had never made before—but I expected it to stop at the sphincter ani. I have of late years been inclined to think that good forceps, properly applied, diminish rather than increase the danger of laceration, an essential point being, during delivery of the head, to keep the handles well forward between the thighs, so as to press the head snugly against

the pubes. In this case, the forehead came under the pubes, and we all know the disadvantage of that. I am not wholly sure but that I may not have carried the handles as far forward as I ought to have done. I thought at the time, I did, however, and you must recollect that I had not full control of the patient just at this time, owing to want of sufficient ether.

This want, gentlemen, allow me to repeat, was the main cause of all my troubles, and of the misery and narrow escape of my poor patient. It was not the difficulty of applying the forceps, nor extracting the child, although that was not an easy task, but my inability to control the movements of the woman that led to the injuries I have detailed. Had it not been for this, the only probable harm would have been an incomplete perineal laceration, which, with sutures and a week's rest, would have entirely healed. The moral is obvious.

It may be of interest to add that this lady has been a subject of vaginismus, not excessive, but to such a degree that copulation was by no means a pleasure. From the time of her recovery, till lately, this sensitiveness has been absent, but at last accounts seemed to be returning.

Boston Medical and Surgical Journal.

BOSTON: THURSDAY, DECEMBER 17, 1874.

WE publish elsewhere a letter from Dr. H. I. Bowditch, in which he criticizes our course towards the American Medical Association. A most careful and dispassionate consideration of the matter has failed to show us reason for changing our views. We are perfectly ready to overlook the insult which the Association was induced to offer to the Massachusetts Medical Society, as the former has been the sole sufferer in consequence of it; but we do not admit that the resolutions passed in 1872 compel us to resume friendly relations, unless we are so inclined. The essence of an apology is an acknowledgment of wrong, and there is no word of this in the resolutions.

Our main objection is that the men who govern the Association and attend its meetings are far from fair representatives of the profession; that, consequently, the proceedings lack the dignity and discretion, and the papers, for the most part, the merit, that should characterize such a body. We cordially admit the former merits and services of the Association, as well as the high standing and character of its former leaders and supporters; but it has wofully degenerated, and Dr. Bowditch does not show the contrary.

There is no doubt that it is desirable to have some good organization to represent the entire country, and if a feasible method of reforming the present one can be devised, we will support it most heartily,

and we shall be glad of suggestions on the subject. We regret to differ from our esteemed correspondent, but we think it our duty to protest against the suggestion implied in the last sentence of his letter: "Upon the action of the District Societies, and not upon the Councillors, *whose power is simply advisory*, the whole matter depends." We can conceive no course more destructive to the good feeling at home and respectability abroad of our Society, than one creating dissensions between the District Societies and the Councillors. Such a course is further unnecessary, for every member has a voice in the election of the Councillors, and, if any of the latter do not represent the views of their constituents, they can, and should, be dropped at the end of their year of service. The Councillors are, for the most part, men of mature years and of high professional standing, to whom the interests of the District Societies may be safely entrusted. If this is not to be done, the very existence of the Council is an absurdity.

THE great feature of the past week, in Boston, has been the trial and conviction of Jesse H. Pomeroy, the boy murderer. The case is a very remarkable one and likely to be quoted as a precedent in future trials, when the defence is based on insanity. Jesse H. Pomeroy, not yet sixteen years of age, from his earliest youth has shown the greatest tendency towards cruelty to children and animals; to witness suffering appears to have been his delight. He was convicted of torturing several children smaller than himself, and, some two or three years ago, was sent to the Reform School for the remainder of his minority. Last February he was released, through the efforts of one of our "philanthropists," whose name has been very carefully hidden from public execration. In April, he enticed a little boy, Horace H. Millen, four years old, to a secluded spot, and murdered him after preliminary tortures too horrible to detail. He endeavored to conceal the body, but it was soon found, and, certain circumstances pointing to him, he at first denied but afterwards admitted the guilt, and confessed, also, another murder.

The evidence, apart from his confession, was conclusive, and the only possible defence was insanity. Drs. Tyler and Walker were the experts for the defence, and Dr. Choate, of New York, for the government, in rebuttal. Dr. Tyler testified that the prisoner had some symptoms of epilepsy, and that the apparent want of motive for his crimes implied mental disorder. On cross-examination, he stated that the gratification of a love for cruelty might be looked upon as a motive, and that the precautions which the boy had uniformly taken to prevent discovery were consistent with sanity and good mental capacity. Dr. Walker was less guarded, and testified that the boy

was insane at the time of the commission of the crime, but on cross-examination was apparently unable to give any reason for his views beyond the great atrocity of the offence. Dr. Choate testified that the boy was of good ability and aware that in committing his crimes he was doing wrong. He did not believe in an irresistible impulse to such crime. He thought the prisoner's mind peculiar in proneness to certain forms of sin, and in weakness to resist. On cross-examination, the witness stated that he thought the peculiarity was moral and not intellectual. He believed the prisoner sane at the time of the crime. After five hours' discussion, the jury returned a verdict of guilty of murder in the first degree, with a recommendation to mercy.

We are equally pleased and surprised at the result, for there are not many juries that would have performed their painful duty so faithfully, and have not been influenced by the attempt to establish insanity. The plea of insanity rested entirely on the difficulty of supposing that merely to gratify a taste for cruelty, a boy should not hesitate to commit such crimes. Now there is no doubt that the tastes of the boy are morbid, but they can hardly be called unnatural except in degree, as a pleasure in tormenting is very common among boys, and in this case it was merely exaggerated. The temptation to commit crime was great, the power to resist, feeble, but there is no reason to doubt that it was sufficient. The verdict is eminently just, and there remains only the dread penalty to be paid. The sooner it is done, the better. We have always favored the strict execution of the laws; but, in this case, there is more than punishment and example to be considered. It is necessary to protect the public against this monster. There is no place but the grave from which silly and reckless sentimentalists will be unable to free him. The very atrocity of his crime will make him interesting to these dreamers, whose philanthropy does not extend to his victims and their heart-broken families.

The Hospitals.

MASSACHUSETTS GENERAL HOSPITAL.

REPORT OF OPERATIONS.

Service of Drs. Bigelow and Cabot. Saturday, December 5, 1874.

SINCE the last report (Nov. 14th), the following cases have been operated upon without ether:—

1. Lithotrity (2 *séances*).
2. Abscess, aspirated.
3. Abscess, aspirated.
4. Wen (of Scalp).

Ether was used in the following cases:—

5. Fistula Ani.
6. Fistula Ani.

7. Fissure of Anus and Fibroid Polypus. Rupture of Sphincter Ani and Excision of Polypus.

8. Hare-lip.

9. Club-foot. Tenotomy of Tibialis Anticus and Plantar Fascia.

10. Club-foot. Tenotomy of Tendo-Achillis.

11. Caries of Ulna.

12. Caries of Femur.

13. Necrosis of Ilium.

14. Warty Growth of Labium.

15. Wen of Back.

16. Nævus of Lip.

17. Cancer of Breast.

18. Tumor of Jaw.

19. Enchondromatous Tumor of Metatarsal Bone.

20. Abscess of Back.

21. Abscess, Palmar.

22. Abscess of Neck.

23. Stricture of Urethra; Divulsion by Voilemier's instrument.

24. Stricture of Urethra; " " " " "

25. Sinus of Stump.

26. Lupus of Nose.

27. Felon.

28. Felon.

29. Felon; Amputation of Finger.

30. Felon; Amputation of Finger.

31. Anchylosis of Arm; old Dislocation at Elbow; Flexion.

32. Phlegmonous Erysipelas.

Lithotrixy.—This patient had been the subject of frequent renal calculus, with subsequent concretion in the bladder, without pain or inflammation, so that there was no occasion for ether. Dr. Bigelow remarked that the simple method of catching the stone in a bladder, moderately distended by water, was in depressing the posterior wall of the bladder into the hollow of the sacrum of the recumbent patient, leaving the female blade of the lithotrite in that position, while the male blade was withdrawn an inch or more. The stone, if loose, as it usually is, then rolls into the instrument. In fact, a stone may be caught and crushed in this way when so small that it is difficult to discover it with a sound. A lithotrite is thus a good sound. The practical termination of the work of a lithotrite is when the female blade is packed above the surface with fine debris. It then becomes difficult to catch fragments which escape from this smooth surface. The instrument must be withdrawn, emptied, and introduced again. Time is thus lost, and the urethra distended and irritated. A lithotrite is needed with a lateral motion of the extremity of the male blade, upon its stalk as a centre, to clear the instrument while in the bladder. Such a contrivance should not impair its strength, and should be subject to guides upon the handle, which should keep the blades parallel while used for crushing, and during withdrawal.

Phlegmonous Erysipelas.—A feeble, middle-aged man had been subjected to the application of a large number of sinapisms for supposed thoracic difficulty. He entered the house for a reddened patch, of the size of two or three hands, extending along the side of the ribs. In two days, this had been developed up and down the side of the body, and now extended from near the axilla to the crest of the ilium. Yet at only one point was there any fluctuation. This was opened, and a small quantity of pus escaped, but the cellular tissue was observed to be in a sloughy condition. The incision was prolonged, and the reddened integument was stripped, with the finger, from this slough so far as it could be discovered, and quite to its edges, leaving a wound, somewhat wider than the hand, extending from the axilla to the ilium. The patient has been well stimulated, and is now, at the end of a fortnight, doing well.

Fistula in Ano.—One of the operations for fistula was instructive; the patient presented himself with an ischio-rectal cavity, from which a large

slough had been detached. The cavity would have contained a hen's egg, which might have been easily lifted out through the patulous orifice. Dr. Bigelow remarked, in looking for a cause for this abscess, that he could find no aperture at its upper part that would admit a probe, but that as the regular position for such communication with the rectum was just above the margin of the anus, he would look there for it. After some examination, the point of the probe passed through a minute sinus, leading to the verge of the anus, where it was felt beneath the mucous membrane. Further cautious exploration discovered an aperture in this membrane, and the probe being passed out at the anus, was followed by a director, and the tissues were divided. Stress was laid upon the importance of discovering these original orifices into the rectum, and it was stated that fifteen minutes might be advantageously consumed, if needed in such exploration, which really constitutes the operation, as the subsequent incision is momentary. A probe often readily passes through the sinus in the sphincter, and is felt beneath the mucous membrane in the anus when a smaller probe is needed to discover the orifice in the latter. If the sinus is not thus traced, it may re-induce the disease. A recent fistula may heal, after operation, in a fortnight; an old one may not heal in years. In such a case, it may be desirable to excise a part of the infiltrated walls, although even this may avail little.

H. H. A. BEACH, M.D., *Surgeon to Out-patients.*

BOSTON CITY HOSPITAL.

Service of Drs. Cheever and Thorndike.

TUESDAY and Friday, Dec. 8th, and 11th, 1874, the surgical operations were as follows:—

1. Tumor of Face.
2. Cancer of Breast.
3. Mammary Abscess.
4. Epithelioma of Nose.
5. Epithelioma of Lip.
6. Necrosis of Tibia from Compound Fracture.
7. Amputation of the Thigh.
8. Necrosis of Radius.
9. Operation for a Deformity of the Lip.

1. This tumor was a recurring myxoma, of six months' growth, in a young woman, 18 years old. It was situated beneath the mucous membrane of the left cheek, and extended up under the zygomatic arch. It was removed from inside the mouth by a crucial incision, and consisted of about four drachms of soft, tenacious, gelatinous substance, which the microscope showed to be a series of fine, delicate, wavy fibres, rounded, mucous-like corpuscles and fat. The first growth was removed by Dr. Cheever, two years ago, in the same way, and was of the same nature as the present one. Dr. Cheever remarked that this is not a malignant growth, like cancer, for, although it has a tendency to return, it does not involve the neighboring structures, nor does it infect the constitution. This specimen comes under the class of hyaline myxoma. According to Bryant, "in the soft myxomas, where the cell-element predominates, the risks of a return are great."

3. An enormous abscess of the breast, of five weeks' duration, in a woman, 45 years old. She has had no children for seven years, and knows of no local injury. A free incision gave exit to a pint and a half of thick, brownish pus. The breast was strapped and supported by a sling.

4. Epithelial disease of the nose, of seven years' growth, in a man, 65 years old. It began as a small crack or abrasion, "where a new pair of brass-bowed spectacles had rested," and in spite of caustics, and various other methods of treatment, it had become an extensive fungous mass, involving the tip, all the lower part of the left, and half of the right, side of the nose, nearly as high as the lower lid. No glandular complication. The growth was entirely removed by the knife; it was necessary to remove a great part

of the nose, but none of the bones. A section of this growth under the microscope showed the whorls, or nests of epithelium-like cells, characteristic of epithelioma. Dr. Thorndike proposes to remedy the deformity by a plastic operation, should the parts get into a favorable condition.

7. Mr. J., aged 25, was run over by the steam cars, October 19th, 1874. His left hand and leg were crushed, and he got a compound fracture of the frontal bone over the outer portion of the left orbit, a piece of the outer table, an inch and a half in diameter, being depressed. Dr. Fifield amputated the forearm at the middle third, and the leg at the knee-joint, by anterior and posterior flaps. Esmarch's bandage was used in both operations, and the loss of blood was slight.

Besides having extensive suppuration, all over the left side of the head, necrosis and great prostration, he had, also, sloughing of the leg-flaps, so that about four inches of the lower end of the femur were exposed. The lower end of the stump is now covered with a large mass of granulations, the bone being nearly closed in, but nature is evidently unequal to the task of healing so large a surface.

Dr. Thorndike amputated the thigh at the middle third, by the circular method, using the rubber bandage and cord, and losing not over an ounce of blood.

8. A boy, 12 years of age, was injured by a sled on the right forearm, three years ago; this was soon followed by periostitis and suppuration. The joints were not implicated, and the hand was in a good condition, the fingers being flexible. Dr. Cheever enlarged the openings, and removed a piece of the shaft of the radius five inches long; this being all that was loose, or ready to be removed, without too much violence. Esmarch's bloodless method was employed, the hand and arm being tightly wound with a rubber bandage. But, instead of the rubber-tubing, a Petit's tourniquet and roller-pad were applied over the brachial vessels. Dr. Cheever preferred this, in the delicate arm of a child, to the risk of injuring the brachial nerves by tight strangulation with the rubber-tubing.

The hæmorrhage was easily controlled by a compress and bandage, after the tourniquet was removed, the operation itself being perfectly bloodless.

9. For a history of this case, see this JOURNAL, April 2d, and June 11th, 1874. The patient is a young woman, 18 years of age, who had a cleft, extending through the soft, and three-fourths of the hard, palate. The former was closed by Dr. Thorndike, in April, in the usual way, and the latter in June, by Fergusson's method. With the exception of a small pinhole at the junction of the hard and soft palate, both operations were successful. The roof of her mouth is broad and well shaped, and the voice has considerably improved. The patient has an unsightly congenital scar and notch on her upper lip, on the same side with the cleft in the palate. It looks like a bad result of a hare-lip operation, but she has never had a hare-lip, and, therefore, no operation for one. Dr. Thorndike cut out the scar, pared the sides of the notch, leaving one side with a flap and the other without, and very carefully apposed the parts with wire and silk sutures. The deformity was completely removed.

GEO. W. GAY, M.D.

Correspondence.

AMERICAN MEDICAL ASSOCIATION.

MESSRS. EDITORS,—Permit me to say a few words in support of the above-named, unfortunate Association. I use the epithet because, at the present time, if we may judge from your JOURNAL and from the action of the Councilors of the Massachusetts Medical Society, it seems to have few friends in Massachusetts.

I was not one of the original founders of it, but I have watched, somewhat closely, its course from its birth.

I also recollect, before its birth, how entirely separated from each other were State Medical Societies, where any existed. The same assertion may be made of individuals of the profession in different parts of the Union. We did not know each other as we do now. The Association arose under the inspiration of one man, and it has been sustained more by his influence than by that of any other individual. I allude to the able, energetic and accomplished physician, N. S. Davis, of Chicago. At first, his labor met with secret or open opposition from many of the older members of the profession in various parts of the country, especially in this State. Massachusetts is only repeating her own earlier history by the position she now takes. If our State had followed the counsel of the late Dr. Enoch Hale, and of some of his compeers, she would have sent no delegates to the earlier meetings. That policy, which would have separated Massachusetts from the Medical Union of these States, was fortunately rejected. And yet your JOURNAL and the Councillors of the State would virtually assume the same position at the present time. You say, in one editorial, that the Society is "rotten," and in your last issue you claim, among the meritorious acts of your editorial career, that you have not lavished "facile eulogy" upon the American Medical Association. Now I am willing to grant that the Association has done a few things of which every one of us disapproves; that, under the influence of some enthusiasts, it has passed votes, which I sincerely wish it had never passed; votes which I thought at that time, and now, were improper and unjust. I grant that meetings have been, at times, disorderly, and that a selfishness worthy of the wildest political gathering has been displayed. Nay, more, of late, all of us have seen, with deep regret, creeping into the Society some of the rather low methods pursued in political meetings. Men have seemed to be voting for themselves, and they have, at least, somewhat openly expressed their claims for office. I grant that, on the part of some few persons, the meetings have also, at times, been disgraced by a drunken rowdiness, unworthy of gentlemen. Give me leave to say that there never was a worse meeting in this last particular than that which occurred in Boston in 1865. That riotous gathering on one of the islands of the harbor, and while under the patronage of the city, was led on by the members of the profession belonging to *Massachusetts*! Granting all these drawbacks, I deny that the Association is "rotten," or that it is unworthy of support.

The Association has existed one quarter of a century. Under the leadership of its distinguished originator, it has grown up strongly, and has done infinite good to the profession throughout the country. It has accommodated itself to the changes which experience has from time to time shown to be necessary in its organization. It has published articles, some of which are valuable, if a great many are not so. It has healthfully stimulated the profession in all parts of our country, and States where no Medical Societies had previously existed have been, by its example and by its precepts, led to form such State Societies. It has adopted a Code of Medical Ethics for the profession of the country. Above all, it has been the means of bringing together some of the best of our profession, men whom we had heard about, but never would have met save at the meetings of this Association, now so scouted at. Some of my sweetest friendships, I have gained only at these meetings; or, if I did not first become acquainted with gentlemen at the meetings, our friendship was cemented at them. I shall never forget that I owe to that held in 1849, at Baltimore, a long and warm friendship with the late Dr. P. C. Gaillard, of South Carolina, than whom I never knew a man nobler in character, or a more thoroughly accomplished gentleman and physician. Nor do I forget that to the American Medical Association I also owe my acquaintance with that wise man and surgeon, the late Dr. Knight, of Connecticut. As a presiding officer, calm, prompt in his decisions; and how friendly and gentle in private intercourse! Really, I cannot understand why men of Massachusetts dislike the American Medical Association.

I have heard but two reasons, viz., first, that the Association has been governed by a set of inferior men, or by men who go to the meetings for their own selfish ends. If this be so, I do not know it. If you look at the

list of Presidents, you will find two from Boston, both of them above reproach in reference to their professional standing, and, in every respect, proper representatives of the Medical Profession of the country. I allude to the late eminent surgeon, Dr. J. C. Warren, and our present living associate, Dr. D. H. Storer. Among our Presidents, certainly, the names of Chapman, of Philadelphia, Stevens, of New York, Warren, of Boston, Mussey, of Cincinnati, Moultrie, of Charleston, Wellford, of Richmond, Knight and Ives, of New Haven, Pitcher, of Detroit, Miller, of Louisville, Pope, of St. Louis, March, of Albany, all of them among the great dead of our profession, and those of others now living, but whose names shall not be mentioned by me, some of whom are among the best of our profession, and the peers of any in any country, prove that, if the Association has been sinking year after year into the hands of an inferior class, it has generally selected no inferior men as its file-leaders. The second objection, and, in the minds of some men of Massachusetts, the stronger objection of the two, is that the Association, at its meeting in Washington, in 1870, grossly insulted the Massachusetts Medical Society. I grant the fact. It was indecorous, on the part of the Association, to exclude delegates from any sovereign State from its meetings under such a flimsy pretence as it excluded for a time those from Massachusetts. The resolution, it will be remembered, however, was carried through the meeting by the energy of one or two *Massachusetts* men.

But, granting that an insult was then offered, was not an ample apology tendered unanimously at the meeting in 1872, at Philadelphia? I submit that, after an insult has been offered and ample reparation made, it is the part of gentlemen to resume at least the semblance of friendly relations.

I cannot forbear, in this connection, remarking that, possibly, the sting of that really insolent rebuke from the American Medical Association was the stimulus that finally goaded our Massachusetts Society to the expulsion of the homœopaths from membership, and that at an expense of several thousand dollars. Moreover, I may add that if the action of the American Medical Association, in the matter of homœopathy, contributed in the least to this end, *so desirable in the eyes of many*, they ought rather to sustain than to try to destroy it, on that account.

In conclusion, I wish to express the hope that the several District Societies of this State will send delegates to the next meeting of the American Medical Association, which is to be holden on the first Tuesday of May next, and during the three following days, at Louisville, Ky. Let each society send its *best men*. If that were always done throughout the country, we should hear but little complaint of the American Medical Association. Upon the action of the District Societies, and not upon the Councillors, *whose power is simply advisory*, the whole matter depends.

Respectfully, Yours,

HENRY I. BOWDITCH.

Boston, Dec. 9, 1874.

Medical Miscellany.

OXALIC ACID is highly extolled by Prof. Ceuni, Prof. Giurley and Dr. Taccani as a local application to the throat in cases of diphtheria.

DR. BAJARDI, an Italian anatomist, has found the superior thyroid artery arising from the common carotid in 37 out of 131 cases. Quain found this anomaly only 41 times in 292 cases.

DR. JAMES H. McDONALD, of Newtonville, appointed Asst.-Surgeon 9th Regt. Inf., M.V.M., has passed a successful examination before the Board of Medical Officers M.V.M.

FOUR CHILDREN, of ages varying from ten months to two years, have recently died at Romford, England, from the effect of "teething powders," administered without medical advice.

TREATMENT OF EPISTAXIS.—Dr. W. I. Wilson, U. S. A., reports the successful employment, in two cases of severe epistaxis, of a solution of the liquor ferri persulphatis, one part to three of water, introduced into the nostril in the form of spray, by means of the ether-spray apparatus. The bleeding was checked in a few seconds.—*Philadelphia Medical Times*.

IRON IN LARGE DOSES.—At an inquest recently held in Manchester England, on the body of a shoemaker, who was an inmate of the Prestwich Lunatic Asylum, and who died suddenly, the *post-mortem* examination showed that the stomach contained one pound ten ounces of nails, some an inch and a half long, several pieces of iron half an inch square, and an awl, without a handle. His death resulted from peritonitis.

MRS. WINSLOW'S SOOTHING SYRUP.—Dr. R. L. Harlow recently read a paper before the Androscoggin Medical Association, in which he justly denounces this poisonous mixture, that has not only killed its hundreds, but is spoiling the health of thousands of children. He states that the amount sold yearly contains over fourteen million grains of morphia, which amount is administered to infants without professional advice.

EPILEPSY CURED BY EXCISION OF A NEUROMA.—At a recent meeting of the Clinical Society of London, Mr. Barwell related an interesting case of a soldier, aged sixty, who had lost an arm in India, in 1846, two years after which epilepsy set in. On examining the stump, a neuroma was found, any pressure on which produced a fit. These fits became at length so numerous, that Mr. Barwell was induced to cut down upon and remove the neuroma. This operation was performed August 7th, and at last accounts (October 24th) the man had had no more epileptic fits, and was much improved in appearance and intellect.

RUPTURE OF THE BLADDER.—A boy, aged eleven years, entered Roosevelt Hospital, July 8th, having been injured July 2d, by receiving a kick in the perineum. There was not much pain complained of at the time, but some hours after he was unable to pass his water, though he did so subsequent to the injury. In the course of a few days the urine became bloody and later purulent, and the patient succumbed August 11th, having manifested symptoms of pelvic peritonitis, diarrhoea and pleurisy. At the autopsy, a rupture was found at the side of the bladder, near the neck, large enough to pass a lead pencil through. The urethra was also ruptured. That the patient did not die shortly after the injury is to be accounted for mainly by the reason that the urine did not escape into the peritoneum.—*New York Medical Journal*, Dec., 1874.

MORTALITY IN MASSACHUSETTS.—Deaths in fifteen Cities and Towns for the week ending December 5, 1874.

Boston, 135; Worcester, 13; Lowell, 18; Milford, 3; Chelsea, 5; Salem, 11; Lawrence, 19; Springfield, 1; Lynn, 9; Gloucester, 4; Fitchburg, 5; Newburyport, 5; Fall River, 16; Haverhill, 4; Holyoke, 7. Total, 255.

Prevalent Diseases.—Consumption, 45; pneumonia, 24; scarlet fever, 15; typhoid fever, 11; croup, 5; diphtheria, 5; measles, 6.

CHAS. F. FOLSOM, M.D.
Secretary of the State Board of Health.

DEATHS IN BOSTON for the week ending Saturday, Dec. 12, 1874. Males, 54; females, 79. Accident, 4; apoplexy, 1; disease of the bladder, 1; inflammation of the brain, 1; disease of the brain, 2; bronchitis, 5; cancer, 1; consumption, 28; convulsions, 2; croup, 1; debility, 3; diarrhoea, 3; dropsy, 1; dropsy of the brain, 4; diabetes, 1; scarlet fever, 5; typhoid fever, 1; gastritis, 2; disease of the heart, 6; hernia, 1; hæmorrhage, 1; disease of the hip, 1; homicide, 2; intemperance, 1; disease of the kidneys, 1; congestion of the lungs, 2; inflammation of the lungs, 15; marasmus, 4; measles, 3; metritis, 1; old age, 7; paralysis, 4; pleurisy, 1; premature birth, 2; peritonitis, 1; pyæmia, 1; puerperal disease, 2; purpura hæmorrhagica, 2; rheumatism, 2; scrofula, 1; tabes mesenterica, 2; tumor, 2; ulcers, 1; unknown, 1.

Under 5 years of age, 39; between 5 and 20 years, 11; between 20 and 40 years, 37; between 40 and 60 years, 20; over 60 years, 26. Born in the United States, 82; Ireland 36; other places, 15.